CHAPTER 1

INTRODUCTION TO THE MEDICARE PROGRAM

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the U.S. Department of Health and Human Services (HHS) that administers and oversees the Medicare, Medicaid, and State Children's Health Insurance Programs and awards contracts to organizations called Contractors who perform claims processing and related administrative functions. Beginning in 2006, all Original Medicare Plan claims processing Contractors (Fiscal Intermediaries [FI], Carriers, and Durable Medical Equipment Carriers) will be transitioned into Medicare Administrative Contractors (MAC). See the Recent Laws That Impact the Medicare Program Section below for additional information about MACs. CMS also regulates laboratory testing and surveys and certifies nursing homes, health care agencies, intermediate care facilities for the mentally retarded, and hospitals. CMS' Central Office is located in Baltimore, Maryland, and provides operational direction and policy guidance for the nationwide administration of the above programs. CMS Regional Offices are located in 10 major cities throughout the U.S. and support the health care provider community by:

- Conducting outreach activities;
- Establishing relationships with local and regional provider associations; and
- Helping providers and suppliers resolve disputes they may have with Contractors.

The Medicare Program

The Medicare Program was established by Title XVIII of the Social Security Act on July 1, 1966. It provides medical coverage to 95 percent of the nation's aged population including individuals age 65 or older, certain disabled individuals, and individuals with End-Stage Renal Disease (ESRD).

Medicare consists of the following four parts:

- Part A, hospital insurance;
- Part B, medical insurance;
- Part C, Medicare Advantage (MA); and
- Part D, prescription drug plan.

Part A

Medicare Part A is hospital insurance. Some of the services that Part A helps pay for include:

- Inpatient hospital care;
- Inpatient care in a Skilled Nursing Facility (SNF) following a covered hospital stay;
- Some home health care; and
- Hospice care.

Part A is financed by:

- Payroll taxes paid by employers and employees through the Federal Insurance Contributions Act;
- Self-employed individual contributions through the Self-Employment Contributions Act; and
- Contributions from railroad workers and their employers or representatives through the Railroad Retirement Act.

Part B

Medicare Part B is medical insurance. Some of the services that Part B helps pay for include:

- Medically necessary services furnished by physicians in a variety of medical settings including but not limited to:
    - The physician's office
    - An inpatient or outpatient hospital setting and
    - Ambulatory Surgical Centers
- Home health care
- Ambulance services
- Clinical laboratory and diagnostic services
- Surgical supplies
- Durable medical equipment and supplies
- Services furnished by practitioners with limited licensing such as:
    - Advanced registered nurse practitioners
    - Independently practicing physical therapists
    - Independently practicing occupational therapists
    - Certified registered nurse anesthetists
    - Licensed clinical social workers
    - Audiologists
    - Nurse midwives
    - Clinical psychologists
    - Physician assistants

Medicare Part B is financed by:

- Premium payments by enrollees;
- Contributions from general Federal government revenues; and
- Interest earned on the Part B trust fund.

Part C or Medicare Advantage

Part C or MA, previously known as Medicare + Choice, is a program through which organizations that contract with CMS provide or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Part A and enrolled in Part B
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

Individuals with ESRD are generally excluded from enrolling in MA Plans.

CMS generally pays the MA organization a fixed amount, or capitation rate, and the MA organization then reimburses providers and suppliers who participate in the MA Plan(s) offered by the MA organization for services furnished within the terms of the agreement/plan.

When the beneficiary is a member of a MA Plan, the plan is responsible for paying claims when a provider or supplier:

- Is affiliated with the MA Plan; or
- Furnishes emergency services, urgently needed services, or other covered services that are not reasonably available through a provider or supplier affiliated with the MA Plan.

Beginning in 2006, the MA Program will include a new option, regional Preferred Provider Organization (PPO) Plans, which are similar to local PPO plans but must have a service area that encompasses one or more of the 26 MA regions established by the Secretary of HHS. Beneficiaries will be able to choose options such as Private Fee-For-Service Plans (PFFS), Health Maintenance Organizations, and local or regional PPO Plans. In addition, these changes provide new opportunities for rural providers and suppliers who may choose to:

- Enter into contracts with MA organizations to furnish health care services to MA enrollees. In general, the provisions of these contracts, including payment rates, are negotiated between MA organizations and providers and suppliers.
- Elect to furnish services to MA enrollees on a non-contract basis. In general, when providers and suppliers furnish services to MA enrollees on a non-contract basis, the MA organization pays them what they would have been paid had they furnished services to beneficiaries in the Original Medicare Plan. Providers and suppliers who elect to furnish services to beneficiaries enrolled in PFFS Plans must follow the PFFS Plan terms and conditions of payment.

Medicare beneficiaries may choose to join or leave a MA Plan during one of the following election periods:

- Initial Coverage Election Period (ICEP), which begins three months immediately before the individual's entitlement to both Medicare Part A and Part B and ends on the later of either the last day of the month preceding entitlement to both Part A and Part B or the last day of the individual's Part B IEP. If the beneficiary chooses to join a Medicare health plan during this period, the Plan must accept him or her unless the Plan has reached its member limit.
- Annual Coordinated Election Period (AEP), which occurs each year between November 15 and December 31. The Plan must accept all enrollments during this time, unless it has reached its member limits. A special AEP for the Medicare prescription drug program will occur from November 15, 2005 through May 15, 2006.
- SEP, during which time the beneficiary may change MA Plans or return to the Original Medicare Plan. One of the following situations must have occurred for the beneficiary to join or leave a plan during this period:
    - He or she permanently moves outside the service area
    - He or she has both Medicare and Medicaid
    - He or she resides in, moves into, or moves out of an institution or
    - Other exceptions as determined by CMS
- Open Enrollment Period (OEP), during which time the beneficiary may leave or join another MA Plan if it is open and accepting new members. Elections made during this period must be made to the same type of plan (regarding Medicare prescription drug coverage) in which the individual is already enrolled. In 2006, the OEP occurs from January through June. In 2007 and beyond, the OEP will occur from January through March. If a plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.

<u>Part D</u>

Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) created Medicare Part D, which provides prescription drug coverage to all beneficiaries electing to enroll in a prescription drug plan beginning on January 1, 2006. Beneficiaries who have Medicare Part A and/or Medicare Part B can enroll between November 15, 2005 and May 15, 2006.

Defined standard coverage in 2006 includes:

- An estimated average $32.20 monthly premium (this is an estimated amount; the premium depends on plan bids and which prescription drug plan or MA Plan the beneficiary selects).
- $250.00 yearly deductible.

- On average 25 percent coinsurance up to an initial coverage limit of $2,250.
- After the initial coverage limit of $2,250 but before the catastrophic limit of $3,600 of true out-of-pocket (TrOOP) spending has been reached, the beneficiary pays 100 percent of prescription drug costs.
- Catastrophic coverage once a beneficiary has spent $3,600 of his or her own money out-of-pocket for the year. This coverage consists of the greater of:
    - A $2.00 copayment for generics and preferred multiple source drugs or a $5.00 copayment for all other drugs or
    - 5 percent of the negotiated price

Beneficiaries will receive the full low-income subsidy, also known as extra help, when:

- Their income is below 135 percent of the Federal poverty level (FPL);
- For 2006, their resources do not exceed three times the amount allowed for Supplemental Security Income (SSI);
- They apply for the subsidy; and
- They are found eligible for the subsidy.

Beneficiaries who receive a full Medicaid benefic package, help from their State Medicaid Program to pay their Medicare premiums, or a cash benefit from SSI will also receive the full low-income subsidy which includes:

- A reduction in the premium, up to the low-income premium subsidy amount for the region, but never to exceed the plan's premium for basic prescription drug coverage.
- No yearly deductible.
- One of the following three copayment structures until a catastrophic limit is reached:
    - A $2.00 copayment for generics and preferred multiple source drugs or a $5.00 copayment for all other drugs
    - A $1.00 copayment for generics and preferred multiple source drugs and a $3.00 copayment for all other drugs for beneficiaries who are eligible for full benefits under Medicare and Medicaid (full-benefit dual eligible beneficiaries) with incomes under 100 percent of the FPL or
    - No copayment for residents of SNFs and other long-term care facilities who are full-benefit dual eligibles
- Once the catastrophic limit of $3,600 out-of-pocket is reached, there is no copayment for all prescriptions. The government subsidy for cost sharing counts toward the out-of-pocket threshold for catastrophic coverage.

There is also a partial subsidy for beneficiaries with limited assets and incomes between 135 and 150 percent of the FPL. This subsidy also applies to beneficiaries with incomes below 135 percent of the FPL if their assets are such that they cannot meet the asset test for incomes below 135 percent of the FPL, but can meet the higher asset test used for those with incomes below 150 percent of the FPL. This coverage includes:

- A premium subsidy based on a sliding scale from no premium subsidy up to the low-income premium subsidy amount for the region, but never to exceed the plan's premium for basic prescription drug coverage.
- $50.00 yearly deductible.
- No more than 15 percent coinsurance up to the catastrophic limit.
- Copayments not to exceed $2.00 for generic or preferred multiple source drugs or $5.00 for all other drugs once the catastrophic limit is reached. The government subsidy for cost sharing counts toward the catastrophic limit.

A new exception to the Anti-Kickback Statute has been added under which pharmacies are permitted to waive or reduce cost-sharing amounts provided they do so in an unadvertised, nonroutine manner after determining that the beneficiary in question is financially needy or after failing to collect the cost-sharing amount despite reasonable efforts. In addition, pharmacies may waive or reduce a beneficiary's Part D cost-sharing without regard to these standards for Part D enrollees eligible for the low-income subsidy provided they do not advertise that the waivers or cost-sharing reductions are available. To the extent that the party paying for cost-sharing on behalf of a Part D enrollee is a group health plan, insurance, government-funded health program, or party to a third party payment arrangement with an obligation to pay for covered Part D drugs, that party's payment will not count toward TrOOP expenditures. Thus, payments made for beneficiary cost-sharing by any entity, including a 340B pharmacy, that has an obligation to pay for covered Part D drugs on behalf of Part D enrollees or voluntarily elects to use public funds for that purpose will not count toward that beneficiary's TrOOP expenditures. By law there are several broad exceptions to the TrOOP requirements, including:

- Assistance provided by family members;
- Help from state pharmaceutical assistance programs;
- Assistance from charities unaffiliated with employers or unions, including patient assistance programs; and
- Low-income cost sharing subsidies.

Medicare beneficiaries may only choose to join or leave a Medicare prescription drug plan during the following enrollment periods:

- IEP Part D: At the beginning of the Medicare prescription drug coverage program, all current Part D eligible individuals have an IEP that begins on November 15, 2005 and ends on May 15, 2006. Individuals who become newly eligible for Medicare will have an IEP for Part D that is the same period as the ICEP for Medicare Part B.
- AEP, which occurs each year between November 15 and December 31. The Medicare prescription drug plan must accept all enrollments during this time. A special AEP for the Medicare prescription drug program will occur from November 15, 2005 through May 15, 2006.
- SEP, during which time the beneficiary may leave or join another Medicare prescription drug plan. One of the following situations must have occurred for the beneficiary to join or leave a plan during this period:
    - He or she permanently moves outside the service area
    - He or she has both Medicare and Medicaid
    - He or she moves into, resides in, or moves out of an institution or
    - Other exceptions as determined by CMS

Medicare Eligibility

There are three groups of Medicare insured beneficiaries:

1) Aged Insured

Aged insured beneficiaries are at least 65 years old and eligible for Social Security, Railroad Retirement, or equivalent Federal benefits. For Medicare purposes, beneficiaries attain age 65 the day before their actual 65th birthday. Medicare Part A is effective on the first day of the month upon attainment of age 65. For an individual whose 65th birthday is on December 1, Part A is effective on November 1 since for Medicare purposes, he or she attained age 65 on November 30. To be eligible for premium-free Part A coverage, an individual must be insured based on his or her own earnings or the earnings of a spouse, parent, or child. Individuals age 65 or older who do not meet insured status requirements for premium-free Part A may enroll in Part A on a premium paying basis if they are entitled to or enrolled in Medicare Part B. **Premium** Part A coverage may be terminated if one of the following occur:

- A voluntary request;
- Nonpayment of premium;
- End of entitlement to Medicare Part B; or
- Death.

Part B coverage is voluntary and becomes effective when an individual enrolls and begins to pay the monthly premium. The period that an individual may enroll in Part B begins 3 months before he or she attains age 65 and lasts for 7 months. If an individual enrolls during the last four months of his or her Initial Enrollment Period (IEP), the Part B effective date will be delayed. If an individual chooses not to enroll in Medicare Part B during the IEP, he or she may enroll during one of the following periods:

- General Enrollment Period, which takes place from January 1 through March 31 of each year. Coverage will be effective on July 1.
- Special Enrollment Period (SEP), which is for those who did not enroll because of current employment or a spouse's current employment and are covered by a Group Health Coverage (GHP). Enrollment may occur:
    - Anytime they are still covered by the GHP through their current employment
    - During the eight months following the month the GHP coverage ends or
    - When employment ends (whichever is first)

All individuals who are entitled to premium-free Part A are eligible to enroll in Part B. Individuals who are not eligible for premium-free Part A can enroll in Part B if they are:

- Age 65;
- A resident of the U.S.; and
- A U.S. citizen or an alien who has been lawfully admitted for permanent residence and has resided continuously in the U.S. during the five years preceding the month in which he or she applies for enrollment.

Medicare Part B may be terminated when one of the following occurs:

- A voluntary request;
- Nonpayment of premium; or
- Death.

2) Disabled Insured

Disabled insured beneficiaries are automatically entitled to Medicare Part A after receiving Social Security disability cash benefits for 24 months and are enrolled in Medicare Part B unless they refuse Part B coverage. This coverage is also available to certain disabled widows, widowers, and disabled children of deceased, disabled, or retired workers. Beginning July 1, 2001, individuals

whose disability is Amyotrophic Lateral Sclerosis are entitled to Medicare the first month they are entitled to Social Security disability cash benefits. Part A terminates:

- The month following the month the notice of disability termination is mailed;
- The attainment of age 65 (entitlement continues as an aged insured); or
- The date of death.

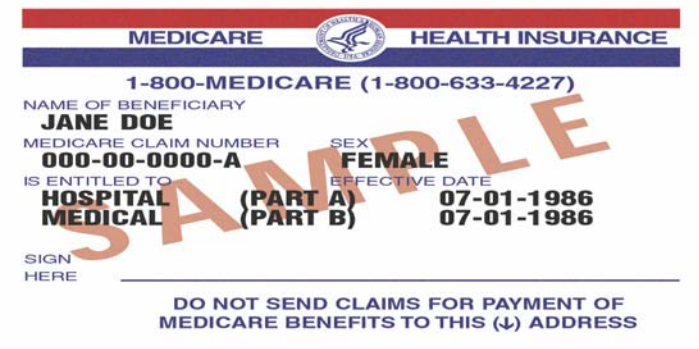
3) End-Stage Renal Disease Insured

ESRD insured beneficiaries are individuals of any age who in order to maintain life receive regular dialysis treatments or a kidney transplant, have filed an application, and meet one of the following conditions:

- Certain work requirements for Social Security insured status (or would meet those requirements if certain Federal government employment qualified as employment for Social Security benefits) or entitled to monthly Social Security benefits;
- Eligible under Railroad Retirement Programs or entitled to an annuity under the Railroad Retirement Act; or
- Is the spouse or dependent child of an insured individual.

Identifying Medicare Beneficiaries

When an individual becomes entitled to Medicare, CMS or the Railroad Retirement Board (RRB) issues a health insurance card like the one depicted below.



Office staff should regularly request the patient's health insurance card and picture identification to verify that services are furnished only to individuals eligible to receive Medicare benefits. Copies of the health insurance card and picture identification should be made for the patient's medical file.

The following information can be found on the health insurance card:

- Name;
- Sex;
- Medicare Health Insurance Claim (HIC) number;
- Effective date of entitlement to Part A; and/or
- Effective date of entitlement to Part B.

The HIC number on the health insurance card issued by CMS has an alpha or alphanumeric suffix and the Social Security Number (SSN), which is usually either the SSN of the insured or the spouse of the insured (depending on whose earnings eligibility is based). The HIC number on the health insurance card issued by the RRB has an alpha prefix and one or more characters and the insured's SSN, a six-digit number, or a nine-digit number.

Organizations That Impact the Medicare Program

The following organizations impact the Medicare Program.

Federal Government

- U.S. House of Representatives
  - Ways and Means Committee
  - Appropriations Committee and
  - Energy and Commerce Committee

- U.S. Senate
  - Appropriations Committee
  - Finance Committee and
  - Energy and Commerce Committee

The *Commerce Clearing House Guide to Medicare and Medicaid* describes proposed legislative changes to the Medicare Program and may be purchased from:

Commerce Clearing House, Inc.
4025 West Peterson Avenue
Chicago, IL 60646-6085
www.cch.com
Telephone: (800) 835-5224

- The Social Security Administration determines eligibility for Medicare benefits and enrolls individuals in Part A and/or B and the Federal Black Lung Benefit Program. It completes the following activities:
  - Replaces lost or stolen Medicare cards
  - Makes address changes
  - Collects premiums from beneficiaries and
  - Educates beneficiaries about coverage and insurance choices

- The Office of Inspector General (OIG) protects the integrity of HHS programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

State Government

- State agencies survey all Medicare Part A and certain Part B providers and suppliers and make recommendations about their suitability for participation in the Medicare Program. State agencies also assist providers and suppliers in sustaining quality standards.

Other Organizations

- Quality Improvement Organizations (QIO) (formerly known as Peer Review Organizations) are organizations that CMS contracts with to:
    - Conduct quality improvement projects
    - Promote the use of publicly-reported performance data
    - Conduct outreach activities for beneficiaries and health care providers and suppliers
    - Respond to written complaints from Medicare beneficiaries or their representatives about the quality of services for which Medicare payment may be made
    - Monitor payment errors to reduce fraud and abuse and
    - Ensure that patient rights are protected

QIOs are required to develop an ongoing process of learning about and contacting organizations in their state that have an interest in health care delivery and policy including organizations that represent disadvantaged communities, rural, and non-English speaking populations. These organizations include major religious, community service, civic, union, consumer, public service, and other organizations. Additional information about QIOs and a link to the directory of QIOs can be found at *www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage* on the CMS website.

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a national program that offers free one-on-one counseling and assistance to people with Medicare and their families through interactive sessions, public education presentations and programs, and media activities. There are SHIPs in all 50 states, Washington, D.C., Puerto Rico, and the Virgin Islands. SHIP-trained counselors provide a wide range of information about long-term care insurance; Medigap; fraud and abuse; and the Medicare, Medicaid, and public benefit programs for those with limited income and assets. To find additional information about SHIPs and a link to State Health Insurance offices, visit *www.cms.hhs.gov/Partnerships/10_SHIPS.asp* on the CMS website.

Recent Laws That Impact the Medicare Program

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
The MMA provides the most dramatic and innovative changes to Medicare since it began in 1965. The chart below depicts Titles I – XII of the MMA.

TITLE	PROVISION
Title I	Medicare Prescription Drug Benefit (see the Part D Section above for information about prescription drug coverage)
Title II	Medicare Advantage
Title III	Combating Waste, Fraud, and Abuse
Title IV	Rural Provisions
Title V	Provisions Relating to Part A
Title VI	Provisions Relating to Part B
Title VII	Provisions Relating to Parts A and B
Title VIII	Cost Containment
Title IX	Administrative Improvements, Regulatory Reduction, and Contracting Reform
Title X	Medicaid and Miscellaneous Provisions
Title XI	Access to Affordable Pharmaceuticals
Title XII	Tax Incentives for Health and Retirement

Medicare Contracting Reform
Section 911 of the MMA enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating FIs and Carriers into new single authorities called MACs. As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts using competitive

procedures. In 2006, MACs will replace all Durable Medical Equipment Regional Carriers and will begin operations to replace Fiscal Intermediaries and Carriers in Arizona, Utah, Montana, Wyoming, North Dakota, and South Dakota. Providers may access the most current Medicare Contracting Reform information to determine the impact of these changes at *www.cms.hhs.gov/MedicareContractingReform* on the CMS website.

Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services

The MMA extended the moratorium on the financial limitation of outpatient physical therapy, occupational therapy, and speech-language pathology services until December 31, 2005. Unless there is a change in the statute, limitations will apply on January 1, 2006. To find updated information on therapy caps, visit *www.cms.hhs.gov/TherapyServices* on the CMS website.

To find additional information about the MMA, visit *www.cms.hhs.gov/MMAUpdate* on the CMS website.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted on August 21, 1996 and established the following:

- National standards for electronic health care transactions and national identifiers for providers, health plans, and employers;
- Safeguards to protect the security and privacy of health data;
- The Health Care Fraud and Abuse Control Account, which helps finance expanded fraud and abuse control activities; and
- Health insurance coverage protection for workers and their families when they change or lose their jobs.

To find additional information about HIPAA, visit *www.cms.hhs.gov/HIPAAGenInfo* on the CMS website.

To find additional information about the Medicare Program, see the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website. Beneficiaries can receive Medicare information 24 hours a day, 7 days a week by visiting *www.medicare.gov* on the Medicare website or by telephoning (800) 633-4227.